Employee Enrollment Application For 51+ Employee Groups Georgia

Anthem Anthem Life

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete electronically or in blue or black ink only.

Employer name	Group no.	Subsection
BURKE COUNTY BOC	GA7911	

Section A Employee information

Last name	First name	M.I.	Social Security no.* (required)

Birthdate (MM/DD/YYYY)	Home address

City	County	State	ZIP code

Sex	Marital status	Primary phone no.
☐ Male ☐ Female	☐ Single ☐ Married	

Employee email address

Employment status	Hire date (MM/DD/YYYY)	No. of hours worked per week
☐ Full time ☐ Part time ☐ Disabled ☐ Retired		

Primary Care Physician (PCP) name	PCP ID no.	Existing patient?
N / A		☐ Yes ☐ No

Section B Application type

Select one

☐ New enrollment
☐ Open enrollment
☐ COBRA –
Select qualifying event
☐ Left employment
☐ Loss of dependent child status
☐ Medicare
☐ Reduction in hours
☐ Divorce or legal separation
☐ Covered employee's Medicare entitlement
☐ Death

Qualifying event date

* Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section C Type of coverage Employee Contribution Required

1. Medical coverage See attached Insurance Cost sheet to determine your payroll contribution(s)

Select network: ☑ POS

Member medical coverage – select one: ☐ Employee only ☐ Employee + Spouse ☐ Employee + child(ren) ☐ Family

2. Medical Coverage Options — Please choose Option 1 or Option 2

☐ OPTION 1-Current Benefits with Plan Changes 7-1-22
-Blue Open Access POS
-OAP5 $1000 Ded- 80/20%- $40/60 copay-$5000oop

☐ OPTION 2 - Alternate Plan 7-1-22
- Blue Essential Open Access POS
- OAP12 $2500 Ded- 70/30%- $7900 oop

3. Dental coverage County Paid: 100% of Employee Only

Enter product selected: Anthem Dental Essential Choice & Complete — See attached Insurance Cost sheet to determine cost of payroll contributions if adding dependent(s).

Member dental coverage – select one: ☐ Employee only ☐ Employee + Spouse ☐ Employee + child(ren) ☐ Family

4. Vision coverage Employee Paid: Voluntary Vision Coverage for Employees & Dependents

Enter product selected: Blue View Vision SM — See attached Insurance Cost sheet to determine your payroll contribution(s) for coverage type, if electing.

Member vision coverage – select one: ☐ Employee only ☐ Employee + Spouse ☐ Employee + child(ren) ☐ Family

5. Life and disability coverage

If you select life and/or disability coverage over the guarantee issue amount or are a late entrant an Evidence of Insurability form may be sent to you to complete.

☒ Basic Life and AD&D County Paid- Employee Only

☐ Basic Dependent Life Employee Paid- Dependent Life Option
See attached Insurance Cost sheet to determine cost of payroll contributions if electing for

Optional Supplemental/Voluntary Dependent Life Spouse $ 20,000.00 (spouse amount)
Optional Supplemental/Voluntary Dependent Life Child $ 10,000.00 (child amount)

County Paid 100% of Employee Only

☒ Long Term Disability

See attached Insurance Cost sheet to determine cost of payroll contributions if electing for dependent(s).

Primary beneficiary **X Employee Signature:** _____ **Date:** _____

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address					Percentage to be paid to beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address					Percentage to be paid to beneficiary

Contingent beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address					Percentage to be paid to beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address					Percentage to be paid to beneficiary

Spousal consent for community property states only (Note: The insurance company is not responsible for the validity of a spouse's consent for designation.)

If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following. I am aware that my spouse, the Employee/ Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse signature X: _____ *Spouse name:* _____ *Date:* _____

Social Security no.* (required)

Section D Coverage information – All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse or your children, or your spouse's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.

Spouse, last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled	Birthdate (MM/DD/YYYY)	Relationship to applicant	Optional Dependent Life
☐ Male ☐ Female	☐ Yes ☐ No		☐ Spouse	☐

Check the type Spousal coverage you are electing:	Medical ☐ Dental ☐	Vision ☐	Height: _____ Weight: _____

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Biological child of applicant/spouse ☐ Other If other, what is relationship? _____

Check the type Dependent coverage you are electing:	Medical ☐ Dental ☐	Vision ☐	Optional Dependent Life ☐

Does this dependent have a different address? ☐ Yes ☐ No

If yes, please enter: _____

Height: _____ Weight: _____

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? _____

Check the type Dependent coverage you are electing:	Medical ☐ Dental ☐	Vision ☐	Optional Dependent Life ☐

Does this dependent have a different address? ☐ Yes ☐ No

If yes, please enter: _____

Height: _____ Weight: _____

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Biological child of applicant/spouse ☐ Other If other, what is relationship? _____

Check the type Dependent coverage you are electing:	Medical ☐ Dental ☐	Vision ☐	Optional Dependent Life ☐

Does this dependent have a different address? ☐ Yes ☐ No

If yes, please enter: _____

Height: _____ Weight: _____

* Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section E Prior and other group coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If yes, give name: ____________________

Medicare ID no.	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date:

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

Are you or a family member previously or currently covered by a Medicare, health and/or dental plan? ☐ Yes ☐ No

If yes, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Policyholder name	Dates (if applicable)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia					Start: End:

Notice of exchange of information to proposed Insured and other persons proposed to be Insured, if any - information regarding your insurability will be treated as confidential

We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 1-866-692-6901.

* Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section F Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

Eligible employee:

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Anthem Blue Cross and Blue Shield (Anthem) as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 30 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

Eligible dependent:

- Employee's spouse, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under state or federal laws.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

In signing this application I represent that: I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage. I certify each Social Security number listed on this application is correct.

For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.

Coverage option: If your employer/group offers HMO coverage which does not permit you to receive the full range of covered services from the provider of your choice, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from the provider of your choice ("point-of-service" plan). This point-of-service plan may be offered by the HMO, Anthem or by another carrier.

Abbreviated Notice of Insurance Information Practices Privacy Act. Georgia state law establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your dependents. We are required to advise you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help us obtain additional medical data from physicians or hospitals.

All data confidential. O.C.G.A. section 33-39-5, subsection (c) (1 through 4) requires that: 1. Personal information may be collected from persons other than the individual or individuals proposed for coverage; 2. Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be disclosed to third parties without authorization; 3. A right of access and correction exists with respect to all personal information collected; 4. The notice prescribed in subsection (b) of the above referenced Code section will be furnished to the applicant or policyholder upon request.

Access to your data. You have the right to see or obtain a photocopy of your personal information which we have. You also have the right to send us a written request if you want any of your personal information to be amended, corrected or deleted. If you wish to have a more detailed explanation of our information practices, please contact Anthem Blue Cross and Blue Shield Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

I'm signing here because I WANT TO GET INFORMATION ABOUT MY BENEFITS BY EMAIL OR ELECTRONICALLY. SUCH ELECTRONIC MAILINGS OR COMMUNICATIONS MAY EVEN INCLUDE CANCELLATION OR NONRENEWAL NOTICES. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.

Sign here	Applicant signature X	Date (MM/DD/YYYY)

SPECIAL ENROLLMENT RIGHTS

If you declined enrollment for yourself or your dependent(s) (including a spouse) because of other health insurance or group health plan coverage, you may be ableto enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if theemployer stops contribution towards your coverage or your dependent's other coverage). However, you must request enrollment within 31 days after coverage ends(or after the employer stops contribution toward the other coverage). In addition, if you have a dependent as a result of marriage, birth, adoption or placement foradoption, you may be able to enroll yourself and your dependent(s) provided that you request enrollment within 31 days after the marriage, birth, adoption orplacement for adoption. I also understand that my dependents and I may enroll under two additional circumstances:-Either your or your dependent's Medicaid orChildren's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or -You or your dependent becomes eligible for a subsidy (statepremium assistance program). In these cases, you may be able to enroll yourself and your dependents provided that you request enrollment within 60 days of theloss of Medicaid/CHIP or of the eligibility determination.

* Anthem is required by the Internal Revenue Service to collect this information.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under Blue Cross/Blue Shield of Georgia Health Plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is Burke County Board of Commissioners at 602 Liberty Street, Waynesboro, Ga 30830. Phone number is (706) 554-2324. COBRA continuation coverage for the plan is administered by COBRA SOLUTIONS AT P.O. BOX 8689, COLUMBUS, GA 31908. PHONE NUMBERS IS (706) 257-1300.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage **must pay** for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or
(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the plan because any of the following qualifying events happens:

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes enrolled in Medicare (part A, Part B, or both);
(5) The parents become divorced or legally separated; or
(6) The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.**

The law also provides that continuation coverage may be cut short for any of the following reasons:

(1) Burke Co. Board of Commissioners no longer provides group health coverage to any of its employees;
(2) The premium for continuation coverage is not paid on time;
(3) The qualified beneficiary becomes covered under another group health plan that does not contain any exclusions or limitation with respect to any preexisting condition that he or she may have;
(4) The qualified beneficiary becomes entitled to Medicare;
(5) the qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

If you have questions

If you have questions about your COBRA continuation coverage, you should contact the Burke County Board of Commissioners, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (ESBA). Addresses and phone numbers of Regional and District ESBA Offices are available through ESBA'S website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

I have received a copy of the Continuation Coverage Rights Under COBRA

Employee Signature_____Date_____

Spouse's Signature(if Applicable)_____Date_____

EMPLOYER CAFETERIA PLAN
SALARY REDIRECTION/REDUCTION AGREEMENT

EMPLOYER: _____

EMPLOYER'S TAX ID NUMBER: _____ - _____

AFFILIATE'S NAME/LOCATION: _____

AFFILIATE'S TAX ID NUMBER: _____ - _____

CAFETERIA PLAN YEAR: ___/___/___ – ___/___/___

(CHECK ONE) ☐ OPEN ENROLLMENT OR ☐ NEWLY ELIGIBLE EMPLOYEE, ELIGIBILITY DATE: ___/___/___

SOCIAL SECURITY NO.: _____ DATE OF BIRTH: ___/___/___ PHONE: (___)_____

NAME: (Last) _____ (First) _____ (Middle Initial)_____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

E-MAIL: _____

No. of Payroll Cycles in Plan Year: ____ Date of First Deduction: ___/___/___ Payroll Mode: ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

On a separate benefit enrollment form(s), I have enrolled for certain benefit or insurance coverage(s) and understand that my required contribution will be deducted from my paycheck by my employer or a third-party payroll administrator. Unless this agreement is amended or terminated, these deductions will be continuous and in an amount equal to my required contribution for my elected coverage as prorated for each payroll period throughout the plan year. The amount of my required contribution has been provided to me. In the event of a rate change, I authorize a corresponding change in the amount deducted from my salary without signing a new Salary Redirection Agreement. Amounts corresponding to employer-provided, nonelective benefits (if any) will not be deducted from my paycheck. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes; therefore, my Social Security benefits could be decreased. I elect to receive the following coverage(s) under the Cafeteria Plan as elected in the Pre-Tax column below. Any previous election and Salary Redirection Agreement under the Cafeteria Plan relating to the same benefits as selected below are hereby revoked. My employer's deduction of any premium/contribution amounts hereunder shall evidence acceptance of this agreement.

Check the desired coverage(s) below. (Note: If this is an annual enrollment, your existing coverage elections will remain the same (as adjusted for any increase/decrease in premium or required contribution) except as indicated below.)

	Pre-Tax	After-Tax		Pre-Tax	After-Tax
Medical Coverage	_____	_____	Specified Health Event Insurance	_____	_____
Dental Insurance	_____	_____	Short-Term Disability Insurance	_____	_____
Vision Insurance	_____	_____	Long-Term Disability Insurance	_____	_____
Cancer Insurance	_____	_____	Hospital Confinement Indemnity Insurance	_____	_____
Hospital Intensive Care Insurance	_____	_____	Personal Sickness Indemnity Insurance	_____	_____
Accident Insurance	_____	_____	Health Savings Account (HSA) §223	_____	_____
Group Term Life Insurance (if family, must be after-tax)	_____	_____	Other accident or health plan(s) under Section 106 of the Internal Revenue Service Code	_____	_____
			List: _____		

Required acknowledgment to participate in Cafeteria Plan:

I certify that the features and benefits under the Cafeteria Plan have been explained to me completely. By initialing, I acknowledge that I understand the Important Information Regarding Participation in the Cafeteria Plan on the back of this form and agree to be bound by those requirements and any other requirements of the Cafeteria Plan.

INITIAL

WAIVER OF PRE-TAX BENEFITS UNDER THE CAFETERIA PLAN:

I elect to waive all pre-tax benefits under the Cafeteria Plan. Except for a change in status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after-tax coverage shall be outside the plan.

INITIAL

EMPLOYEE'S SIGNATURE: _____ **DATE:** _____

Payroll Authorization Form

	EE Only	EE+Child(ren)	EE+Spouse	Family
Dental				
Vision				
Dependent Life - $2.77				
Medical Option 1				
Medical Option 2				

Employee Signature_____Date_____

Print Name_____

Changes Effective 7/1/2022

Dental Bi-weekly rates:

EE Only	100% paid by County
EE Child(ren)	$12.13
EE + Spouse	$10.60
Family	$23.44

Vision Bi-weekly rates:

EE Only	$2.58
EE Child(ren)	$5.16
EE + Spouse	$4.91
Family	$7.59

Health Bi-weekly rates option 1:

EE Only	$53.30
EE Child(ren)	$207.90
EE + Spouse	$223.89
Family	$325.17

Health Bi-weekly rates option 2:

EE Only	$45.26
EE Child(ren)	$176.53
EE + Spouse	$190.11
Family	$276.11